 m General

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

July 5, 1983

51

MEMORANDUM TO LEGISLATIVE LIAISON OFFICER:

Department of Agriculture
Department of Education
Department of Energy
Department of Housing and Urban Development
Department of the Interior
Department of Justice
Department of State
Agency for International Development
Central Intelligence Agency
Environmental Protection Agency
National Aeronautics and Space Administration
Tennessee Valley Authority
U.S. Information Agency
Veterans Administration

SUBJECT: Office of Personnel Management (OPM) draft bill, the "Federal Employees Health Benefits Reform Act of 1983".

Attached, for your information, is a copy of OPM's draft bill to reform the FEHB program, as transmitted to the Congress on June 21, 1983.

The bill was circulated for comment only to members of the Cabinet Council on Management and Administration, which had considered this legislation.

Naomi R Sweeney

Naomi R. Sweeney
Acting Assistant Director
for Legislative Reference

Attachment

United States
Office of
Personnel Management

Washington, D.C. 20415
June 21, 1983

In Reply Refer To: Your Reference:

Honorable George Bush
President of the Senate
Washington, D.C. 20510

Dear Mr. President:

The Office of Personnel Management submits herewith a legislative proposal, "To restructure the Federal Employees Health Benefits Program to strengthen financial control over the Program and enhance competition among participating health plans, and for other purposes." We request that you refer this proposal to the appropriate committee for early consideration.

Our plan utilizes what is popularly known as the "voucher" approach. It embodies an exciting free-market method of providing health insurance for Federal employees, and will give them the greatest possible choice in selecting health plans for themselves and their families. It will also enable the Federal Government to get a firm grip on its cost of providing benefits under the Program. It will get the Federal Government out of the business of designing benefit packages and setting premium rates, and will allow participating insurance companies to design a range of benefit offerings and rates to suit a variety of individual needs at an appropriate cost, subject to minimum requirements with respect to catastrophic protection which all plans will be required to offer. Market forces will determine the rates, and enrollees will therefore enjoy attractive benefits at the lowest cost. It will continue the traditional policy of allowing retiring Federal workers to continue enrollment in the plans participating in the FEHB Program.

While the current FEHB Program offers considerable choice to employees and retirees, our proposal is designed to greatly enhance this choice. For example, the current definition of "carrier" in section 8901(8) of title 5, United States Code, would be broadened in order to open much wider the door to participation in the Program. Eligible plans would now include: (1) plans offered by any legal entity licensed to market group health insurance, provided that the insurer is licensed to do business in a State or the District of Columbia where the plan is offered to FEHB enrollees, and plans offered by individual Blue Cross and Blue Shield corporations; (2) employee organization-sponsored plans, and (3) all Federally qualified health maintenance organizations (HMO's). In addition, the new definition of "carrier" offers the possibility of adding regional plans to the others listed above. Reinsurance requirements will ensure financial stability of the plans in the Program. All health plans presently in the Program will be offered the opportunity to continue to participate, and the new reinsurance requirements will not apply to currently participating plans, provided they are financially stable.

Under this bill, the Government will no longer intrude into the relationship between an enrollee and the insurance company by negotiating detailed contracts with carriers which set out benefits and rates. OPM's statutory authority to negotiate such contracts would be dropped, and eligible carriers would simply submit proposed plans to OPM for approval. This approval would be given, basically, if the carrier certifies that it will offer group health insurance to all eligible enrollees: (1) at rates consistent with the lowest rates the carrier offers for comparable policies; (2) which provides a minimum level of catastrophic protection, taking into account enrollee payments for such medical, hospital, and surgical services as may be specified by OPM regulations; and (3) with acceptable conversion rights for those who involuntarily lose their group eligibility.

These features provide the opportunity for a wide variety of insurance carriers to participate in the program and to offer as many different levels of coverage as they wish, at premium rates which may range from an amount approximating the amount of the Government contribution to much higher amounts sufficient to provide extensive coverage beyond the catastrophic protection, e.g., full or co-payment for services below the catastrophic deductible.. The enrollee would thus be free to spend as much or as little out of pocket as he desires for varying levels of coverage and would continue to have the convenience of payroll and annuity deduction of any premium in excess of the Government contribution. No longer will the Government decide for him the amount of additional coverage that will be available, or how much he will have to spend to get it.

The bill would further require each employing office and retirement system to issue to their eligible employees and annuitants such materials as OPM may prescribe for purposes of facilitating a choice among available health benefits plans. The legislation would call on OPM "to take such steps as it considers appropriate and feasible to ensure that comparative information will be available to enrollees," particularly encouraging and assisting private sector initiatives in this regard. In a departure from present practice, the bill specifies that the carrier of each health plan will be responsible for providing enrollees with a detailed, written plan description in a format approved by OPM. Presently, OPM must produce these brochures, and Government expenses will be greatly reduced by placing this responsibility with the carriers. Our measure also would require carriers to grant OPM and GAO access to plan records, and to have in place a satisfactory utilization review system.

The present system ties the Government contribution to high option rates charged by six of the largest carriers in the Program. This means that cost to the Government is driven by benefits offered by these plans alone. We propose to replace this system with one in which the reformed FEHB Program would start out with a specific Government contribution (based on the average contribution rate during the year prior to inauguration of the new system) for two kinds of coverage: self-only, and self-and-family. In each succeeding year, these amounts would be adjusted in accordance with the percentage change in the implicit price deflator for the Gross National Product over

the 12-month period ending March 31 preceding the new plan year, as determined by OPM based upon GNP calculations published by the Bureau of Economic Analysis of the U.S. Department of Commerce. This new method for determining the Government's contribution will result in substantial savings in Government outlays under the FEHB system in future years, because of the establishment of an indexed contribution rate.

An important change, with major implications for cost and utilization control in the health care industry, involves elimination of the current "75 percent rule." Under current law, the Government can pay no more than 75 percent of the total premium of any FEHB plan. This tends to discourage enrollees from selecting good low-option plans which otherwise may meet their needs. Our bill would allow the Government contribution to fund the entire premium cost of any health benefits plan and, if an enrollee elects a less comprehensive plan with a premium cost below the available Government contribution, the enrollee would be entitled to receive a cash rebate equal to the amount of any excess Government contribution, except that such rebate may not exceed 40 percent of the authorized Government contribution in each case. This can be expected to encourage enrollees to select lower cost plans, with their built-in incentives for avoiding over-utilization of health care services.

Another funding feature would require that the U.S. Postal Service and the District of Columbia government assume the financial responsibility for Government contributions on behalf of their retired employees or their survivors and forward the appropriate amounts to OPM for deposit in the Employees Health Benefits Fund. This provision would eliminate what is now an unintended subsidy under the FEHB program for off-budget agencies due to the fact that the FEHB law has historically authorized annual appropriations for FEHB contributions on behalf of all annuitants. In addition, the Department of Labor would make contributions on behalf of those receiving workers' compensation benefits, and charge such benefits back to the former employing agency.

OPM's administration of the new FEHB system would be financed by a contribution from Federal agencies for each enrollment, not to exceed one percent of the basic Government premium contribution rates. Administrative expenses would continue to be subject to limitations specified each year by Congress. This agency would continue to receive all Government and enrollee contributions and forward appropriate payments to participating health plans.

In addition to the already existing statutory provision for an administrative reserve in the Employees Health Benefits Fund, this bill establishes an enrollees' contingency reserve account, to which OPM may credit amounts which accrue to the general Fund over and above the amounts due the carriers, and any unobligated balances remaining in current health plan contingency reserve accounts after the transition to the new system is complete. The new reserve would be available, without fiscal year limitation, for payment of expenses which OPM deems proper for the benefit of FEHB enrollees.

Section 4 of the legislation would amend the Retired Federal Employees Health Benefits Act (RFEHBA) by abolishing the old Government-wide "Uniform Plan" as of December 31, 1983. On January 1, 1984, remaining

enrollees in the old plan would be transferred automatically to the Government-wide Indemnity Benefit Plan, in FEHBP, at an appropriate level of benefits. Like the Uniform Plan, the Indemnity Benefit Plan is underwritten by the Aetna Life Insurance Company. The Uniform Plan enrolls only a closed and rapidly declining population--employees who retired before July 1, 1960, or the survivors of employees who retired or died before that date--who, due to their advancing ages, experience high utilization of benefits. Continuation of the Uniform Plan would require substantial annual premium increases which plan enrollees can ill afford, since they typically receive small annuities. Automatic transfer of these enrollees to low-option coverage under the Indemnity Benefit Plan will provide these individuals with much better overall coverage at a lower cost. Section 4 of our bill would also transfer any contingency reserves or other monies credited to the Uniform Plan to the FEHB Fund, to the credit of the low-option contingency reserve of the Indemnity Benefit Plan.

The Office of Management and Budget advises that enactment of this proposal would be in accord with the program of the President.

A similar letter is being sent to the President of the Senate.

Sincerely yours,

Donald J. Devine
Director

OVERVIEW

Federal Employees Health Benefits Reform Act of 1983

This legislative proposal, developed by the Office of Personnel Management, would restructure and reform the Federal Employees Health Benefits Program to achieve a number of important objectives:

- Encourage vouchered competition among health benefits plans by opening program to a broader range of private insurance carriers, to allow more choice to employees and to encourage price competition among plans.

- Decrease Government intrusion into the benefit design and rate setting of these private insurance plans, and rely on market forces instead to encourage carriers to offer the most attractive benefits at the lowest rates, subject to minimum requirements with respect to catastrophic protection.

- Give Federal employees and annuitants a broader range of plans, with different benefits and rates, from which to choose a health benefits package best suited to the needs of themselves and their families.

- Control costs to the Government, by replacing the present benefit-driven Government contribution formula with a new formula indexed to the percentage change in the implicit price deflator for the Gross National Product.

- Encourage employees and annuitants to select lower cost plans, with their built-in incentives for discouraging overutilization of services, by removing the present 75 percent limitation on the Government contribution toward the cost of any particular health plan or level of benefits and by authorizing cash rebates of up to 40 percent of the authorized Government contribution rate in cases of enrollees who select health benefits plans which cost less than such contribution.

- Reduce administrative expenses for the entire program by lessening Government involvement in the private health plans and their relationship with their enrollees.

- Require OPM to declare a 30-day open enrollment season in advance of any changes in benefits or premiums under approved health plans.

SUMMARY

A Bill

"To restructure the Federal Employees Health Benefits Program to strengthen financial control over the Program and enhance competition among participating health plans, and for other purposes."

The FEHB Program needs major reform to set it on a firm course for the future, so that the interests of enrollees and the Government are protected. This bill is designed to preserve the best features of the current Program while solving the problems.

Section 1

This Act may be cited as the "Federal Employees Health Benefits Reform Act of 1983."

Section 2

Subsection 2(a) of the bill would revise and reenact the current Federal Employees Health Benefits (FEHB) law (5 U.S.C., ch. 89) as follows:

§8901. Definitions

The definitions in the current section 8901 would be essentially reenacted with the notable exception of "carrier." The new definition would broaden health plan participation to include (A) Government-wide, regional, or local plans offered by one or more Blue Cross and Blue Shield corporations or by any legal entity licensed to market group health insurance in the State in which the plan is offered; (B) additional employee organization-sponsored plans; and (C) all Federally qualified health maintenance organizations (HMO's).

§8902. Qualified Health Benefits Plans

The law would no longer authorize OPM to contract with carriers for FEHB plans. Eligible carriers would be required to submit proposed plans for OPM approval which would be accorded if the carrier certifies that group insurance benefits will be offered to all eligible FEHB participants: (1) at rates consistent with the carrier's lowest schedule of rates for comparable policies; (2) in accordance with minimum catastrophic protection requirements specified by OPM regulations; and (3) with acceptable conversion rights upon involuntary termination of group eligibility. Reinsurance requirements would ensure the financial stability of plans.

This section also requires carriers to provide enrollees with a detailed plan description in a format approved by OPM, to grant OPM and GAO access to plan records, and to have in place a satisfactory utilization review system.

§8903. Enrollment Procedures

This section essentially reenacts current provisions of law.

Each employing office and retirement system would be required to issue to their eligible employees and annuitants such materials as OPM may prescribe for purposes of facilitating a choice among available health benefits plans, including: a list of plans and their respective premium rates, instructions for obtaining detailed information on benefits from carriers, and a health care voucher form on which to register a choice of plan. OPM would see to it that comparative information on plans is made available to enrollees.

§8904. Government Contributions and Enrollee Premiums

The most important correction needed is in calculating the Government contribution to health benefits premiums. The current formula which ties that contribution to the average premium for the highest level of benefits offered by six of the plans with the largest FEHB enrollments is too unpredictable. The proposal would replace this formula with specified contribution rates which would be amounts equal to the average Government contribution rate in the preceding plan year for self-only and self-and-family enrollments, respectively, indexed in accordance with the percentage change in the implicit price deflator for the Gross National Product over the 12-month period ending March 31 preceding each plan year, as determined by OPM based on GNP calculations published by the Bureau of Economic Analysis of the U.S. Department of Commerce.

Another change would be to eliminate the current 75 percent limitation on the Government contribution toward the cost of a particular plan or level of benefits in order to encourage enrollees to select lower cost plans, possibly at no enrollee cost. Moreover, if an enrollee elects a health plan with a premium cost below the available Government contribution, the enrollee would be entitled to receive a cash rebate equal to the amount of any excess Government contributions, except that such rebate may not exceed 40 percent of the authorized Government contribution in each case. Health plan premiums in excess of the basic Government contribution would be withheld from the enrollee's pay or annuity.

In addition to the basic Government contribution, Government agencies would contribute an amount for each enrollment, as determined necessary by OPM but not to exceed one percent of the basic Government premium contribution rate, to fund OPM's administration of the law. Expenditures for administrative expenses would be subject to limitations imposed each year by Congress. OPM would continue to receive all Government contributions and enrollee withholdings and to forward appropriate payments to participating health plans.

The proposal would further improve Program financing by requiring the Postal Service and the District of Columbia government to assume responsibility for payment of Government contributions on behalf of their retired employees, or their survivors, as well as requiring the Department of Labor to make contributions on behalf of recipients of workers' compensation benefits and charge such amounts back to the former employing agency.

§8905. Coverage of Reinstated Employees and Restored Annuitants

This section essentially reenacts 5 U.S.C. 8908.

§8906. Employees Health Benefits Fund

In addition to the existing administrative reserve, an enrollees' contingency reserve account would be established in the Fund, to which OPM may credit any amounts which accrue to the general Fund in excess of premium payments due carriers and, pursuant to section 3 of the bill, any balance remaining in existing health plan contingency reserve accounts in the Fund at the end of two years after termination of final contracts entered into under current provisions of 5 U.S.C. 8902. The newly created reserve would be available, without fiscal year limitation, for payment of expenses which OPM deems proper for the benefit of FEHB enrollees.

§8907. Studies and Reports

This section essentially reenacts 5 U.S.C. 8910.

§8908. Jurisdiction of Courts

This section essentially reenacts 5 U.S.C. 8912.

§8909. Regulations

This section substantially reenacts 5 U.S.C. 8913.

Section 2(b) of the bill would make the amendments to chapter 89 of title 5, United States Code, effective with respect to health plan enrollments and Government contributions on and after October 1, 1984. To ensure that the new provisions will be fully implemented on the specified effective date, the bill would authorize OPM to automatically assign current FEHB enrollees who do not specify a choice with respect to health plan coverage under the new program to an appropriate successor health plan. Also, section 2(b) would permit currently operating FEHB plans to continue under the new program without meeting the new reinsurance requirements, provided they are financially stable.

Section 3

Section 3(a) would amend existing FEHB law to provide that all contracts which become effective in January 1984 shall terminate effective September 30, 1984.

Section 3(b) would provide that any balance in health plan contingency reserve accounts in the Employees Health Benefits Fund shall be transferred to the enrollees' contingency reserve account established under section 8906(c) of title 5, United States Code, as amended by section 2 of this bill, effective October 1, 1986.

Section 3(c) would provide that the administrative reserve account in the Employees Health Benefits Fund immediately prior to the effective date of section 2 of this bill shall be available without limitation to meet OPM's expenses for implementation of this law.

Section 4

The Retired Federal Employees Health Benefits Act would be amended to abolish the Government-wide Uniform Plan, effective December 31, 1983. Then, effective January 1, 1984, any remaining Uniform Plan enrollees would be automatically transferred to an appropriate level of benefits under the Government-wide Indemnity Benefit Plan under the FEHB Program.

A BILL

To restructure the Federal Employees Health Benefits Program to strengthen financial control over the Program and enhance competition among participating health benefits plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Federal Employees Health Benefits Reform Act of 1983".

Sec. 2. (a) Chapter 89 of title 5, United States Code, is revised and reenacted as follows:

"CHAPTER 89--EMPLOYEE HEALTH INSURANCE

"§8901. Definitions

"For purposes of this chapter--

"(1) 'employee' means--

"(A) an employee as defined by section 2105 of this title;

"(B) a Member of Congress as defined by section 2106 of this title;

"(C) a Congressional employee as defined by section 2107 of this title;

"(D) the President;

"(E) an individual employed by the government of the District of Columbia, unless otherwise provided by the District of Columbia Council in accordance with section 714(c) of the Act of December 24, 1973 (87 Stat. 819);

"(F) officers and employees of the United States Postal Service, unless otherwise provided by the Postal Service in accordance with section 1005(f) of title 39, United States Code;

"(G) an individual employed by Gallaudet College;

"(H) an individual employed by a county committee established under section 590h(b) of title 16; and

"(I) an individual appointed to a position on the office staff of a former President under section 1(b) of the Act of August 25, 1958 (72 Stat. 838);

but does not include--

"(i) an employee of a corporation supervised by the Farm Credit Administration if private interests elect or appoint a member of the board of directors;

"(ii) an individual who is not a citizen or national of the United States and whose permanent duty station is outside the United States, unless the individual was an employee for the purpose of this chapter on September 30, 1979, by reason of service in an Executive agency, the United States Postal Service, or the Smithsonian Institution in the area which was then known as the Canal Zone;

"(iii) an employee of the Tennessee Valley Authority; or

"(iv) an employee excluded by regulation of the Office of Personnel Management under section 8909(b) of this title;

"(2) 'Government' means the Government of the United States and the government of the District of Columbia;

"(3) "annuitant" means--

"(A) an employee who retires on an immediate annuity under subchapter III of chapter 83 of this title or another retirement system for employees of the Government, after five or more years of service or for disability;

"(B) a family member who receives an immediate annuity as the survivor of an employee or of a retired employee described by sub-paragraph (A) of this paragraph;

"(C) an employee who receives monthly compensation under subchapter I of chapter 81 of this title and who is determined by the Secretary of Labor to be unable to return to duty; and

"(D) a family member who receives monthly compensation under subchapter I of chapter 81 of this title as the surviving beneficiary of—

"(i) an employee who died as a result of injury or illness compensable under that subchapter; or

"(ii) a former employee who died while receiving monthly compensation under the subchapter and who had been held by the Secretary to have been unable to return to duty;

"(4) 'service', as used in paragraph (3) of this section, means service which is creditable under subchapter III of chapter 83 of this title;

"(5) 'family member' means the spouse of an employee or annuitant and an unmarried dependent child under 22 years of age, including--

"(A) an adopted child or recognized natural child; and

"(B) a stepchild or foster child, but only if the child lives with the employee or annuitant in a regular parent-child relationship; or such an unmarried dependent child regardless of age who is incapable of self-support because of mental or physical disability which existed before age 22;

"(6) 'dependent', in the case of any child, means that the employee or annuitant involved is either living with or contributing to the support of such child, as determined in accordance with such regulations as the Office shall prescribe, or if the employee or annuitant is deceased, the deceased individual lived with or contributed to the support of such child immediately before death;

"(7) 'health benefits plan' means a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services;

"(8) 'carrier' means--

"(A) one or more not-for-profit corporations which are organized and authorized under the laws of a State or the District of Columbia for the primary purpose of operating a service benefit health plan, or plans, under which prepaid hospital, medical, surgical, and related services are provided to subscribers to such plan or plans pursuant to participation agreements between the corporation and physicians, hospitals,

and other providers of health services, or any legal entity which is licensed under the laws of a State or the District of Columbia to issue group health insurance policies providing indemnity benefits to covered individuals for specified health care expenses and which chooses to offer a qualified health benefits plan, or plans, under this chapter;

"(B) an employee organization, as defined in paragraph (9) of this section, which sponsors, and administers in whole or in substantial part, a health plan available only to individuals, and their family members, who are regular or associate members of the organization, provided however, that if an employee organization elects to offer limited associate memberships for purposes of health plan participation under this chapter, associate memberships must be offered equally to all employees and annuitants eligible to enroll in a qualified health benefits plan pursuant to this chapter;

"(C) a Federally qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300e-9(d)(1)); and

"(D) any corporation, association, partnership, or other organization which contracted with the Office of Personnel Management as of September 30, 1984, to offer a comprehensive medical plan or network of plans described in section 8903(4) of this title as then in effect, provided such organization continuously offers such qualified health benefits plan or network of plans under this chapter after September 30, 1984;

"(9) 'employee organization' means an association or other organization of employees or retired employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a qualified health benefits plan under this chapter;

"(10) 'open enrollment season' means a 30-day period, which shall be designated by the Office of Personnel Management prior to the beginning of any plan year with respect to which changes in premium rates or benefits are approved by the Office in its administration of this chapter, during which period any eligible employee who is not enrolled in a qualified health benefits plan described in section 8902 of this title may enroll and any enrolled employee or annuitant may change his enrollment to another plan or benefits option;

"(11) 'health care voucher' means a document for use in enrolling in a health benefits plan or changing enrollment to another plan or benefits option pursuant to this chapter on which an individual shall indicate a choice of a qualified health benefits plan and level of benefits, if applicable, under this chapter; and

"(12) 'plan year' means the twelve-month period beginning each October 1, corresponding to the Federal Government's fiscal year.

"§8902. Qualified health benefits plans.

"(a) A carrier, as defined in section 8901(8) of this title, that wishes to offer one or more group health insurance plans to employees and annuitants pursuant to this chapter shall apply for approval of such plan or plans by the Office of Personnel Management in such manner as the Office may require by regulation. The Office shall approve all plans as qualified for participation under this chapter which satisfy the following conditions:

"(1) The carrier shall certify that premium charges for enrollments under this chapter in each level of benefits of the plan shall be consistent with the lowest schedule of rates charged for comparable benefits levels under the carrier's other group policies;

"(2) The carrier shall certify that each level of benefits under a proposed plan will provide comprehensive benefits for covered services and supplies provided to an enrollee or eligible family member in any plan year, with no out-of-pocket expenditure by the enrollee, after the enrollee has incurred creditable deductible and coinsurance expenditures in that plan year equal to a maximum enrollee financial participation requirement which shall be specified under the terms of the plan, and which shall not be greater than a maximum permissible enrollee financial participation amount which the Office establishes as appropriate for that category of health plan, and which shall take into consideration enrollee payments for such services as medical, hospital, and surgical benefits, as the Office determines appropriate;

"(3) The carrier agrees to offer each level of benefits to all eligible enrollees at a uniform premium rate for self-only enrollments, and a uniform premium rate for self-and-family enrollments, for a term of at least one plan year;

"(4) The carrier shall agree to operate, or contract for, a health services utilization review system satisfactory to the Office;

"(5) The carrier shall agree to accept for enrollment, without regard to race, sex, health status, or age, and in accordance with procedures established pursuant to section 8903 of this title, any employee or annuitant who is eligible to enroll in a qualified

health benefits plan pursuant to this chapter and, if the employee or annuitant so elects, family members, as defined in section 8901(5) of this title, provided, however, that plans offered by carriers described in subparagraph (B) of section 8901(8) of this title shall be open to employees and annuitants who reside in a State (or the District of Columbia) in which the carrier is licensed to do business, and plans offered by carriers described in subparagraph (B) of section 8901(8) of this title shall be open only to employees and annuitants who at the time of enrollment are members or associate members of the sponsoring employee organization, and plans offered by carriers described in subparagraphs (C) and (D) of section 8901(8) of this title may be limited to employees and annuitants who live or work in the geographic area served by a particular plan;

"(6) The carrier shall agree to provide detailed written statements of the rights and obligations of the plan and its enrollees, including services and benefits to which plan enrollees are entitled and any maximums, limitations, and exclusions applicable to such services and benefits, in a format approved by the Office, and to provide an enrollee identification card, and a description of procedures for obtaining benefits, to all who enroll in the plan pursuant to this chapter;

"(7) The carrier shall agree that if, during the course of a plan year, an enrollee changes his enrollment to another health benefits plan under conditions prescribed by this chapter, or applicable regulations issued by the Office, the former health plan shall permit such enrollee to terminate enrollment and shall not require any premium or other payment after enrollment in the plan is terminated;

"(8) The carrier shall agree to offer each employee, annuitant, or family member whose eligibility under this chapter is ended, except by voluntary cancellation of health plan enrollment, a 31-day extension of coverage during which such individual shall have the option to convert without evidence of good health to a nongroup contract with the carrier providing health benefits. Such nongroup contract shall provide benefits at least equal to the lowest level of benefits offered under the qualified health benefits plan from which the individual terminated. The premium for such nongroup contract shall be consistent with the lowest rates charged by the carrier under comparable nongroup policies. Any individual who exercises this conversion option shall pay the full periodic premium charges of the nongroup contract directly to the carrier;

"(9) The carrier shall furnish to the Office such evidence as the Office may require that the carrier has obtained adequate reinsurance of its health benefits plan against loss, except that the Office may waive such requirement for reinsurance if the carrier petitions the Office for such waiver, on the basis that such reinsurance is unnecessary because of the carrier's financial stability and capacity for risk absorption;

"(10) The carrier shall agree to furnish such reports as the Office determines to be necessary to enable the Office to carry out its functions under this chapter, and to permit the Office and representatives of the General Accounting Office to examine such records of the carrier as may be necessary to determine the carrier's financial stability and otherwise carry out the purposes of this chapter.

"(b) Approval of a ~~plan~~ for participation under this chapter as a qualified health benefits plan may be withdrawn by the Office, after notice of the reasons for withdrawal and opportunity for a hearing for the carrier concerned and without regard to subchapter II of chapter 5 and chapter 7 of this title, if the Office determines that the plan is not in compliance with any provision of this chapter or applicable regulations.

"(c) The provisions of any health benefits plan approved by the Office for participation under this chapter, which provisions are set forth in a written plan description furnished to enrollees pursuant to subsection (a)(6) of this section and relate to the nature or extent of coverage or benefits (including payments with respect to benefits), shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance and plans or the format of informational materials, to the extent that such law or regulation is inconsistent with such provisions.

"§8903. Enrollment procedures.

"(a) Each eligible employee shall, upon entering on duty, be issued by the employing office a list of qualified health benefits plans available pursuant to this chapter and the applicable premium rates, and a health care voucher, as described in section 8901(11) of this title, on which to indicate a choice of plans and, if applicable, level of benefits, and whether his enrollment is for self-only or for self-and-family.

"(b) An annuitant who at the time he becomes an annuitant has been enrolled in a qualified health benefits plan pursuant to this chapter--

"(1) as an employee for a period of not less than--

"(A) the five years of service immediately before retirement; or

"(B) the full period or periods of service between the last day of the first period in which he was eligible to enroll in a health benefits plan under this chapter (or similar provisions of prior law) and the date on which he becomes an annuitant, if less than five years; or

"(2) as a family member of an employee or annuitant;

shall continue to be eligible while an annuitant to be enrolled in a qualified health benefits plan pursuant to this chapter so long as such individual remains continuously enrolled in any health benefits plan pursuant to this chapter.

"(c) If an employee or annuitant has a spouse who is also an employee or annuitant, either spouse, but not both, may enroll in a qualified health benefits plan for self-and-family coverage or each spouse may enroll as an individual. However, an individual may not be enrolled both individually as an employee or annuitant and as a family member of another enrollee.

"(d) Each eligible employee and annuitant shall, at the beginning of each open enrollment season, be issued, by his employing office or retirement system, such materials as the Office may prescribe for purposes of facilitating a choice among available health benefits plans, including: a list of qualified health benefits plans and their respective premium rates, instructions for obtaining benefit brochures from carriers, and a health care voucher to be completed and returned to the individual's employing office or retirement system indicating his choice of plan, level of benefits, and whether the enrollment is for self-only or self-and-family coverage. The Office shall take such steps as it considers appropriate and feasible to ensure that comparative information on available qualified

health benefits plan is available to each eligible employee and annuitant during each open enrollment season. Employees and annuitants who are enrolled in a qualified health benefits plan under this chapter and who do not complete and return the health care voucher to their employing office or retirement system during the open enrollment season to change their enrollment shall continue to be enrolled in the same health benefits plan or, in the event such plan ceases participation under this chapter, in a plan which is reasonably similar to the discontinued plan, as determined by the Office.

"(e) An employee or annuitant may, under conditions prescribed by regulations of the Office, be issued a health care voucher for the purpose of changing his coverage, or that of himself and his family members, upon application filed with the employing office or retirement system within 60 days after a change in family status.

"(f) An employee or annuitant may be issued a health care voucher for use in transferring his enrollment from one qualified health benefits plan to another if the health benefits plan in which such individual is enrolled ceases participation under this chapter, and at such other times and under conditions prescribed by regulations of the Office.

"(g)(1) Each employing office or retirement system to which a completed health care voucher is returned by an eligible employee or annuitant under the provisions of this section shall promptly send a copy of the completed voucher to the carrier selected by the employee or annuitant.

"(2) Each employing office or retirement system that is responsible for the enrollment of employees or annuitants in qualified health benefits plans under this chapter shall promptly notify the affected carrier, in a manner to be prescribed by the Office, if an employee or annuitant becomes ineligible for continued coverage under that carrier's plan because the

employee or annuitant has elected to transfer his enrollment to another carrier in accordance with the procedures under this section or has separated from the service or otherwise became ineligible for continued coverage.

"(3) Each employing office or retirement system that is responsible for the enrollment of employees or annuitants in qualified health benefits plans under this chapter shall, at the beginning of each calendar year and in a manner to be prescribed by the Office, transmit to each carrier a list of all employees or annuitants for whom the employing office or retirement system is responsible and who are enrolled in the carrier's plan, together with an identification of the level of benefits under which the employee or annuitant is covered and whether the coverage is for self-only or self-and-family.

"§8904. Government contributions and enrollee premiums.

"(a)(1) The Office of Personnel Management shall determine in advance of each plan year the basic rates of Government contributions available under this chapter toward the premium cost of self-only and self-and-family enrollments, respectively, in qualified health benefits plans, in accordance with the provisions of this subsection.

"(2) For purposes of determining the Government contribution rates per enrollee for each plan year, the Office shall first determine for the fiscal year preceding the new plan year the average biweekly Government contribution made toward self-only and self-and-family health plan enrollments under this chapter, respectively, on behalf of enrollees other than active and retired officers and employees of the United States Postal Service and the survivors of such individuals, including in such average Government contribution the amount of any excess Government contribution paid to employees and annuitants

under subsection (c)(1) of this section. The Office shall then adjust such average contribution rates in accordance with the Office's determination of the percentage change in the implicit price deflator for the Gross National Product for the calendar quarter ending March 31 immediately preceding a new plan year, relative to the implicit price deflator for the Gross National Product for the calendar quarter ending the preceding March 31, as such quarterly figures are published by the Bureau of Economic Analysis of the Department of Commerce.

"(3) The Office shall provide for conversion of biweekly rates of Government contributions and enrollee premiums determined under this section to rates for employees and annuitants paid on other than a biweekly basis, and for this purpose may provide for the adjustment of the converted rate to the nearest cent.

"(b)(1) Except as provided by paragraph (2) of this subsection and paragraph (2) of subsection (e) of this section, for all periods during which an enrollment under this chapter continues, a Government contribution as determined by the Office under subsection (a) of this section shall be payable on behalf of each enrolled employee and annuitant. For employees, adjustments in the Government premium contribution rates computed by the Office in accordance with subsection (a) of this section and changes in health benefits plan premium rates shall take effect on the first day of the first pay period beginning on or after the beginning of the plan year. For an annuitant, the adjustments in contribution and premium rates shall take effect on the first day of the plan year.

"(2) In the case of an enrolled employee who is occupying a position on less than a full-time basis, the biweekly Government contribution shall

be an amount which bears the same ratio to the adjusted contribution rates determined under subsection (a) of this section as the average number of hours of such employee's regularly scheduled workweek bears to the average number of hours in the regularly scheduled workweek of an employee serving in a comparable position on a full-time basis (as determined under regulations prescribed by the Office).

"(c)(1) Each employee or annuitant who elects to enroll in a qualified health benefits plan pursuant to this chapter shall be responsible for payment of any group premium charge applicable to such enrollment in excess of the biweekly Government contribution authorized under subsection (b) of this section for each pay period during which the enrollment continues. Withholdings for this purpose shall be made from the pay of each enrolled employee and the annuity of each enrolled annuitant.

"(2) If the periodic Government contribution rate authorized under subsection (b) of this section for self-only or self-and-family health plan enrollments exceeds the periodic premium charge for an approved health benefits plan and enrollment category selected by an eligible employee or annuitant under this chapter, the excess Government contribution shall be paid directly to the enrolled employee or annuitant each pay period in accordance with subsections (f) and (g) of this section, but only to the extent that such excess amount does not exceed 40 percent of the authorized Government contribution rate.

"(d) In addition to Government contributions authorized under subsection (b) of this section, there shall be contributed by the Government for each enrollment an amount which the Office determines to be necessary for administrative costs in accordance with section 8906(b) of this title.

"(e)(1) An employee enrolled in a health benefits plan under this

chapter who is placed in a leave without pay status may have his coverage and the coverage of his family members continued under the plan for not to exceed one year, subject to payment of the appropriate amounts by the Government and the enrollee as required by subsections (b) and (c) of this section.

"(2) An employee who enters on approved leave without pay to serve as a full-time officer or employee of a labor organization, as defined by section 7103(a)(4) of this title, may, within 60 days after entering on that leave without pay, file with his employing agency an election to continue his enrollment under this chapter and arrange to pay currently into the Employees Health Benefits Fund, through his employing agency, both employee and agency contributions from the beginning of the period of leave without pay. The employing agency shall forward the enrollment charges so paid to the Office for deposit to the Fund. If the employee does not so elect, his enrollment will be subject to paragraph (1) of this subsection and implementing regulations.

"(f) The Government contributions toward health plan premiums and administrative costs under this section for an employee, and any payments to employees under subsection (c)(2) of this section, shall be paid--

"(1) in the case of employees generally, from the appropriation or fund which is used to pay the employee;

"(2) in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment;

"(3) in the case of an employee of the legislative branch who is

paid by the Clerk of the House of Representatives, from the contingent fund of the House; and

"(4) in the case of an employee in a leave without pay status, from the appropriation or fund which would be used to pay the employee if he were in a pay status.

"(g)(1) Except as provided in paragraphs (2), (3), and (4) of this subsection, Government contributions toward health plan premiums and administrative costs authorized under this section relative to annuitant enrollments under this chapter, and any payments to annuitants under subsection (c)(2) of this section, shall be paid by the Office from annual appropriations which are authorized to be made for that purpose and which may be made available until expended.

"(2) In the case of annuitants who are retired officers or employees of the United States Postal Service or the Post Office Department, or the survivors of such individuals, the United States Postal Service shall pay all Government contributions authorized by this section and shall forward contributions required by subsections (b) and (d) of this section to the Employees Health Benefits Fund upon notification by the Office of the amounts which the Office determines are necessary for this purpose.

"(3) In the case of annuitants who are retired officers or employees of the government of the District of Columbia, or the survivors of such individuals, the District of Columbia government shall pay all Government contributions authorized by this section and shall forward contributions required by subsections (b) and (d) of this section to the Employees Health Benefits Fund upon notification by the Office of the amounts which

the Office determines are necessary for this purpose.

"(4) In the case of annuitants who receive monthly compensation under subchapter I of chapter 81 of this title, all Government contributions authorized by this section shall be paid from the Employees' Compensation Fund established under section 8147(a) of this title, with such contributions charged back to the former employing agency in accordance with section 8147(b) of this title. The Secretary of Labor shall authorize payment to the Employees Health Benefits Fund of contributions required by subsections (b) and (d) of this section upon notification by the Office of the amounts the Office determines are necessary for this purpose.

"(h)(1) In accordance with regulations prescribed by the Office, an employing agency or retirement system which fails to collect enrollee premium contributions and forward them, along with Government contributions toward health plan premiums and administrative expenses, to the Office in the correct amounts and in a timely manner for deposit to the credit of the Employees Health Benefits Fund shall be liable for the appropriate amounts, plus interest at a rate determined by the Office and computed from the time such payment should have been forwarded to the Office.

"(2) If an agency fails to withhold the proper amount of health benefits premium contributions from an individual's salary, compensation, or retirement annuity, the collection of unpaid premiums may be waived by the agency if, in the judgment of the agency, the individual is without fault and recovery would be against equity and good conscience. However, if the agency so waives the collection of unpaid enrollee premium contributions, the agency shall submit an amount equal to the sum of the

uncollected enrollee contributions and appropriate Government contributions, plus interest, as required by paragraph (1) of this subsection.

"(i) The Office shall forward enrollee premium contributions and applicable Government premium contributions for enrollees in each health benefits plan to the carrier no later than 30 days after such monies are received by the Office for deposit to the Employees Health Benefits Fund.

"§8905. Coverage of reinstated employees and restored annuitants.

"(a) An employee enrolled in a health benefits plan under this chapter who is removed or suspended without pay and later reinstated or restored to duty on the grounds that the removal or suspension was unjustified or unwarranted may, at his option, be issued a health care voucher for purposes of enrolling as a new employee or have his coverage restored, with appropriate adjustments made in contributions and claims, to the same extent and effect as though the removal or suspension had not taken place.

"(b) A disability annuitant whose annuity under section 8337 of this title, or a similar provision of another retirement system for employees of the Government, is terminated because the annuitant recovers from disability or is restored to an earning capacity fairly comparable to the current rate of pay of the position occupied at the time of retirement, and whose annuity is later restored due to recurrence of the disability or loss of earning capacity, shall upon such restoration, be issued a health care voucher by his retirement system for purposes of enrolling in a health benefits plan pursuant to this chapter, if such annuitant was covered by any such plan immediately prior to the termination of annuity.

"(c) A surviving spouse whose survivor annuity under this title was

terminated because of remarriage and is later restored shall, under such regulations as the Office of Personnel Management may prescribe, be issued a health care voucher by the retirement system for purposes of enrolling in a health benefits plan under this chapter, if such spouse was covered by any such plan immediately before such annuity was terminated.

"§8906. Employees Health Benefits Fund.

"(a) Pursuant to this section and similar provisions of prior law, there is authorized to be in the Treasury of the United States an Employees Health Benefits Fund which shall be administered by the Office of Personnel Management. The contributions of employees, annuitants, and the Government toward health plan premium charges and administrative expenses prescribed by section 8904 of this title shall be paid into the Fund. The Fund, other than accounts identified for specific purposes under this section and the Retired Federal Employees Health Benefits Act (74 Stat. 850), is available, without fiscal year limitation, for payments by the Office to approved health benefits plans of premium charges with respect to enrollments under this chapter.

"(b) An amount, as determined by the Office to be necessary from time to time, but not to exceed one percent of the Government contribution rates as determined by the Office pursuant to section 8904(a)(2) of this title, shall be set aside from Government contributions paid into the Fund for each enrollment during a plan year under section 8904 of this title as an administrative expense reserve to be available, within the limitations that may be specified annually by Congress, to pay the administrative expenses incurred by the Office under this chapter.

"(c) There shall be an enrollees' contingency reserve account in the Fund. The Office, from time to time and in amounts it considers appropriate, may transfer any amounts credited to the general Employees Health Benefits Fund in prior plan years in excess of premiums due carriers to the enrollees' contingency reserve account. This account shall be available to the Office, without fiscal year limitation, for payment of any expenses which the Office may, in its discretion, deem proper for the benefit of individuals enrolled in health plans pursuant to this chapter.

"(d) The Secretary of the Treasury may invest and reinvest any of the money in the Fund which is not immediately required for premium payments to carriers, administrative expenses, or authorized disbursements from the enrollee contingency reserve, in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations shall become a part of the enrollees' contingency reserve in the Fund as authorized under subsection (c) of this section.

"§8907. Studies and reports.

"(a) The Office of Personnel Management shall make a continuing study of the operation and administration of this chapter, including surveys and reports on health benefits plans available to employees and on the experience of the plans.

"(b) Each Government agency shall keep such records, make such certifications, and furnish the Office with such information and reports as may be necessary to enable the Office to carry out its functions under this chapter.

"§8908. Jurisdiction of courts.

"The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court, of a civil action or claim against the United States founded on this chapter.

"§8909. Regulations.

"(a) The Office of Personnel Management shall prescribe regulations necessary to carry out the purposes of this chapter.

"(b) The regulations of the Office may exclude an employee from coverage under this chapter on the basis of the nature and type of his employment or conditions pertaining to it, such as short-term appointments, seasonal or intermittent employment, and employment of like nature. The Office may not exclude--

"(1) an employee or group of employees solely on the basis of the hazardous nature of employment;

"(2) a teacher in the employ of the Board of Education of the District of Columbia, whose pay is fixed by section 1501 of title 31, District of Columbia Code, on the basis of the fact that the teacher is serving under a temporary appointment if the teacher has been so employed by the Board for a period or periods totaling not less than two school years; or

"(3) an employee solely on the basis of occupying a position on a part-time career employment basis (as defined in section 3402(2) of this title).

"(c) The regulations of the Office shall provide for the beginning and ending dates of coverage of employees and annuitants and their family

members under health benefits plans. The regulations may require the coverage to continue, exclusive of the temporary extension of coverage described by section 8902(a)(8) of this title, until the end of the pay period in which an employee is separated from the service, or until the end of the month in which an annuitant ceases to be entitled to annuity, and in case of the death of an employee or annuitant, may permit a temporary extension of the coverage of his family members for not to exceed 90 days.

"(d) The Secretary of Agriculture shall prescribe regulations to effect the application and operation of this chapter to an individual named by section 8901(1)(H) of this title.".

(b) (1) The amendments made by subsection (a) of this section shall take effect on October 1, 1984, and shall be effective with respect to health plan enrollments and Government contributions under chapter 89 of title 5, United States Code, on and after that date, and the Office of Personnel Management shall take such steps as it considers necessary prior to that date, including scheduling a special open enrollment season, to ensure that such provisions will be able to be implemented on that date. The Office may, with respect to enrollees in health benefits plans available pursuant to chapter 89 of title 5, United States Code, before October 1, 1984, automatically assign any individuals who do not specify a choice with respect to health plan coverage effective on and after that date to an appropriate level of benefits in a successor plan offered by the same carrier, or, in the event such carrier is no longer a participant under this chapter, to a plan which the Office determines is reasonably similar to the individual's health plan coverage under this chapter before

October 1, 1984, unless the individual enrollee gives notice in accordance with regulations prescribed by the Office that the automatic assignment is unacceptable.

(2) Notwithstanding section 8902(a)(9) of title 5, United States Code as amended by subsection (a) of this section, any carrier that, on the day before the date of enactment of this Act, is operating a health benefits plan under chapter 89 of title 5, as in effect before the amendments made by subsection (a) shall not be subject to the requirements of such section 8902(a)(9), provided that the Office of Personnel Management determines such carrier to be financially stable.

Sec. 3. (a) Section 8902(a) of title 5, United States Code, as in effect prior to October 1, 1984, is amended on the date of enactment of this Act by adding the following sentence at the end thereof:

"Notwithstanding the foregoing sentence, all contracts for health plans under this chapter which become effective as of January 1984 shall terminate effective September 30, 1984."

(b) Contingency reserve funds set aside in the Employees Health Benefits Fund for individual health benefits plans pursuant to section 8909(b)(2) of title 5, United States Code, as in effect on September 30, 1984, shall for a period of two years beyond termination of health plan contracts pursuant to section 8902(a) of title 5, United States Code, as amended by subsection (a) of this section, remain available to pay accrued claims against the respective health benefits plans to the extent that the Office of Personnel Management determines that other reserves held by the

carrier of a terminated plan are insufficient to liquidate outstanding claims. Effective October 1, 1986, the Office shall determine the total of any individual health plan contingency reserve accounts remaining in the Employees Health Benefits Fund, and shall transfer all such contingency reserve funds, together with any interest income earned from the investment of such funds by the Secretary of the Treasury in interest-bearing obligations of the United States, to the enrollees' contingency reserve account established in the Employees Health Benefits Fund pursuant to section 8906(c) of title 5, United States Code.

(c) Any unused administrative reserve funds set aside in the Employees Health Benefits Fund pursuant to subsection 8909(b)(1) of title 5, United States Code, as in effect immediately before the effective date of section 2 of this Act, shall be available, without limitation, to pay administrative expenses incurred by the Office in implementing the provisions of this Act.

Sec. 4. (a) The Retired Federal Employees Health Benefits Act (74 Stat. 849) is amended as follows:

(1) The word "Commission" is deleted wherever it appears and the words "Office of Personnel Management" substituted in place thereof;

(2) Section 2(1) is amended to read:

"(1) the terms 'employee' and 'Government' have the same meanings when used in this Act as such terms have for purposes of section 8901 of title 5, United States Code.";

(3) Sections 3, 5, and 10 are repealed;

(4) Section 4 is amended by replacing the first two sentences with the following sentence:

"If a retired employee enrolls for self-only in a health benefits plan as provided for by section 6 of this Act, the Government shall contribute each month toward his subscription charge an amount equal to the current monthly premium of an individual for each month under section 1839(c)(3) of the Social Security Act.";

(5) Section 6(a) is amended in the first sentence by striking out ", other than the plan provided for under section 3 of this Act,";

(6) Section 7 is amended to read:

"Each retired employee shall, within such time after March 1, 1961, as the Office of Personnel Management shall prescribe, notify the Office of his election to enroll in or retain existing coverage in a private health benefits plan and receive Government contributions under section 6 of this Act, or not to participate in the program offered under this Act. If the retired employee elects to enroll under this section, his election shall be accompanied by a certificate of the carrier certifying the fact of his enrollment and the cost to him of the health benefits plan, or of the health benefits portion of the plan.";

(7) Section 8 is amended to read:

"(a) The Government contribution toward the cost of enrollments in private health benefits plans under sections 4 and 6 of this Act, and expenses incurred by the Office of Personnel Management in the administration of this Act, shall be paid from funds that shall be

credited for this purpose by the Secretary of the Treasury, out of money in the Treasury of the United States which is not otherwise appropriated, to the Employees Health Benefits Fund established in the Treasury of the United States for purposes of chapter 89 of title 5, United States Code, upon notification by the Office of the amounts which the Office determines are necessary for purposes of this section.

"(b) The funds credited to the Employees Health Benefits Fund under subsection (a) of this section shall be available without fiscal year limitation for payment of the Government contributions provided for by sections 4 and 6 of this Act through agencies of the Government which administer a retirement system for employees of the Government and for expenses incurred by the Office in administering this Act.";

(8) The first sentence of section 9(b) is repealed;

(9) Section 9(c) is amended by--

(A) striking out ", and withholdings required by section 5 of this Act" in clause (4);

(B) repealing clause (6); and

(C) striking out the words "and withholding" in clause (8); and

(10) Section 12 is amended by striking out the words "and withholdings".

(b) Subsection (a) of this section becomes effective on January 1, 1984. On that date, all monies credited to the Retired Employees Health Benefits Fund in the Treasury of the United States shall, except as provided by subsection (d) of this section, be transferred to the Employees Health Benefits Fund established pursuant to section 8909 of title 5, United States Code, and set aside for purposes of the Retired Federal Employees Health Benefits Act.

(c) Each individual enrolled in the Government-wide plan pursuant to section 3 of the Retired Federal Employees Health Benefits Act on December 31, 1983, shall be automatically transferred to an appropriate level of benefits under the Indemnity Benefit Plan described in paragraph (2) of section 8903 of title 5, United States Code, as in effect on the date of enactment of this Act, effective January 1, 1984, unless the individual elects enrollment in another type of plan described in section 8903.

(d) Effective January 1, 1984, any contingency reserve to the credit of the Government-wide plan under the Retired Employees Health Benefits Act, and any monies received on or after that date with respect to enrollments in such plan, shall be transferred to the contingency reserve of the Indemnity Benefit Plan in the Employees Health Benefits Fund established under section 8909(b) of title 5, United States Code, which contingency reserve shall be made available for payment of any outstanding obligations of the terminated Government-wide plan.